SECTION 8

Post-acute care

Skilled nursing facilities
Home health services
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1. Number of post-acute care providers increased or remained stable in 2012

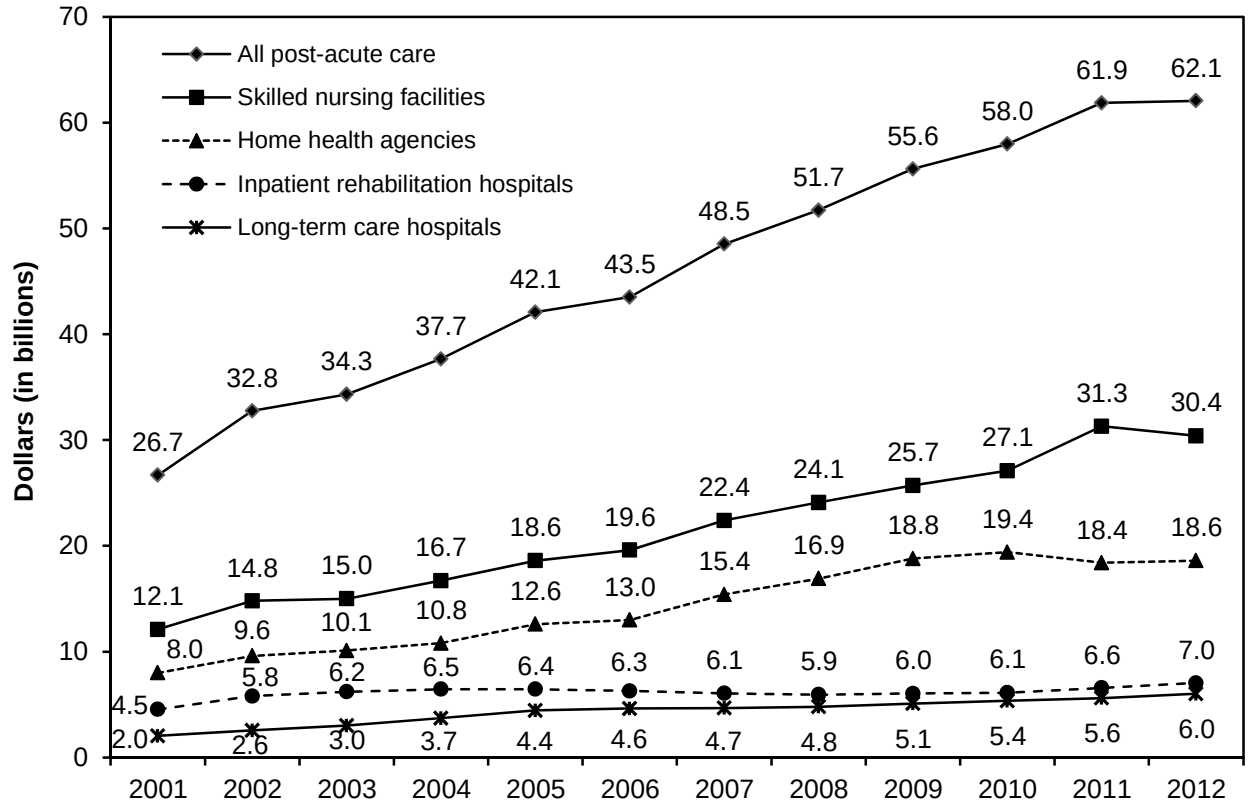
	2004	2005	2006	2007	2008	2009	2010	2011	2012	Average annual percent change 2004–2011	Percent change 2011–2012
Home health agencies	7,804	8,314	8,955	9,404	10,040	10,961	11,654	12,026	12,225	6.4%	1.7%
Inpatient rehabilitation facilities	1,221	1,235	1,225	1,202	1,202	1,196	1,179	1,165	1,166	–0.7	0.1
Long-term care hospitals	353	388	392	402	496	427	438	437	437	3.6	0.0
Skilled nursing facilities	14,981	15,026	15,017	15,047	15,024	15,062	15,076	15,120	15,139	0.1	0.1

Note: The skilled nursing facility count does not include swing beds.

Source: MedPAC analysis of data from the Provider of Services files from CMS.

- The number of home health agencies has increased substantially since 2004. The number of agencies increased by 199 in 2012. The growth in new agencies is concentrated in a few areas of the country.
- In spite of a moratorium on new long-term care hospitals (LTCHs) beginning in October 2007, the number of these facilities continued to grow through 2010. The number of LTCHs remained constant from 2011 to 2012.
- The total number of skilled nursing facilities has increased slightly since 2004, and the mix of facilities continues to shift from hospital-based to freestanding facilities. In 2012, hospital-based facilities made up 5 percent of all facilities, down from 10 percent in 2003.

Chart 8-2. Home health care and skilled nursing facilities have fueled growth in Medicare's post-acute care expenditures



Note: These numbers are program spending only and do not include beneficiary copayments.

Source: CMS Office of the Actuary.

- Increases in fee-for-service (FFS) spending on post-acute care have slowed in part due to expanded enrollment in managed care, whose spending is not included in this chart.

- FFS spending on inpatient rehabilitation hospitals declined from 2005 through 2008, reflecting policies intended to ensure that patients who do not need this intensity of services are treated in less intensive settings. However, spending on inpatient rehabilitation hospitals has increased since 2009.

- FFS spending on skilled nursing facilities increased sharply in 2011, reflecting CMS's adjustment for the implementation of the new case-mix groups (resource utilization groups, version IV) beginning October 2010. Once CMS established that the adjustment it made was too large, it lowered the adjustment and spending dropped in 2012.

Chart 8-3. A growing share of fee-for-service Medicare stays and payments go to freestanding skilled nursing facilities and for-profit facilities

	Facilities		Medicare-covered stays		Medicare payments	
Type of SNF	2006	2011	2006	2011	2006	2011
All SNFs	100%	100%	100%	100%	100%	100%
Freestanding	92	95	89	93	94	97
Hospital based	8	5	11	7	6	3
Urban	67	71	79	81	81	84
Rural	33	29	21	19	19	16
For profit	68	70	67	72	73	76
Nonprofit	26	25	29	25	24	21
Government	5	5	4	3	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding or missing information about facility characteristics.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files, 2006 and 2011.

- Freestanding SNFs made up 95 percent of facilities in 2011.
- Freestanding SNFs treated 93 percent of Medicare-covered stays and accounted for 97 percent of Medicare payments in 2011.
- For-profit facilities made up 70 percent of facilities in 2011. Between 2006 and 2011, their share of Medicare-covered stays increased 5 percentage points (from 67 percent to 72 percent) and their share of payments increased 3 percentage points.
- Urban SNFs' share of facilities, Medicare-covered stays, and payments increased between 2006 and 2011.

Chart 8-4. SNF volume remained essentially unchanged between 2010 and 2011

	2006	2008	2010	2011	Change 2010–2011
Volume per 1,000 fee-for-service beneficiaries					
Covered admissions	72	73	71.5	71.2	–0.3%
Covered days	1,892	1,977	1,938	1,935	–0.2
Covered days per admission	26.3	27.0	27.1	27.2	0.4

Note: SNF (skilled nursing facility). Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Information Services

- Between 2010 and 2011, Medicare-covered admissions and days remained essentially unchanged, after declining slightly from 2008. Despite the modest declines, the covered days and covered days per admission were higher than in 2006.

Chart 8-5. Freestanding SNF Medicare margins have increased steadily since 2005

Type of SNF	2005	2006	2007	2008	2009	2010	2011[a]
All	13.1%	13.3%	14.7%	16.6%	18.0%	18.5%	22% to 24%
Urban	12.6	13.1	14.5	16.3	17.9	18.5	N/A
Rural	15.2	14.3	15.5	18.0	18.7	18.4	N/A
For profit	15.2	15.7	17.2	19.1	20.2	20.7	N/A
Nonprofit	4.5	3.5	4.1	6.9	9.6	9.5	N/A
Government[b]	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: SNF (skilled nursing facility), N/A (not applicable).
[a] Medicare margin for 2011 is estimated because Medicare cost reports were not available. The range is based on assumptions about days, revenues, and costs.
[b] Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of freestanding SNF cost reports.

- We estimate the 2011 Medicare margin to be between 22 percent and 24 percent. Medicare cost reports were not available to calculate Medicare margins for 2011.
- Although aggregate Medicare margins for freestanding SNFs have varied over the past 7 years, they have exceeded 10 percent every year since 2001 (early years not shown).
- Aggregate Medicare margins increased from 2009 to 2010 due to costs per day growing slower than payments per day. The growth in payments reflected the increased share of days classified into the highest paying resource utilization groups.
- Examining the distribution of 2010 margins, one-half of freestanding SNFs had margins of 18.9 percent or more (not shown). One-quarter had Medicare margins at or below 9 percent and one-quarter had margins of 26.9 percent or higher.

Chart 8-6. Comparison of beneficiaries who do and do not use skilled nursing facilities, 2010

Characteristic	Percent of beneficiaries who: Use SNF services	Do not use SNF services
Sex		
Female	59%	54%
Male	41	46
Race/ethnicity		
White, non-Hispanic	85	79
African American	10	9
Hispanic	2	6
Other	2	5
Age (in years)		
<65	8	18
65–74	20	45
75–84	34	25
85+	39	12
Self-reported health status		
Excellent or very good	13	43
Good or fair	68	48
Poor	19	8
Limitations in ADLs		
No ADLs	26	69
1–2 ADLs	25	19
3–6 ADLs	49	12
Education		
No high school diploma	32	23
Completed high school	29	30
Beyond high school	36	46
Living arrangement		
In an institution	33	4
Alone	28	29
With a spouse	23	49
Other	15	18
Eligibility status		
Aged, no ESRD	82	89
Aged with ESRD	1	3
Disabled	17	7
Dual eligible	33	17

Note: SNF (skilled nursing facility), ADL (activity of daily living), ESRD (end-stage renal disease). Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey 2010 cost and use files.

- Beneficiaries who use SNF services are older, more frail, and more likely to report poor health status compared with other beneficiaries.
- Beneficiaries who use SNF services are more likely to be disabled and dually eligible for Medicare and Medicaid.

Chart 8-7. Comparison of users of skilled nursing facilities: Dual-eligible users and other users, 2011

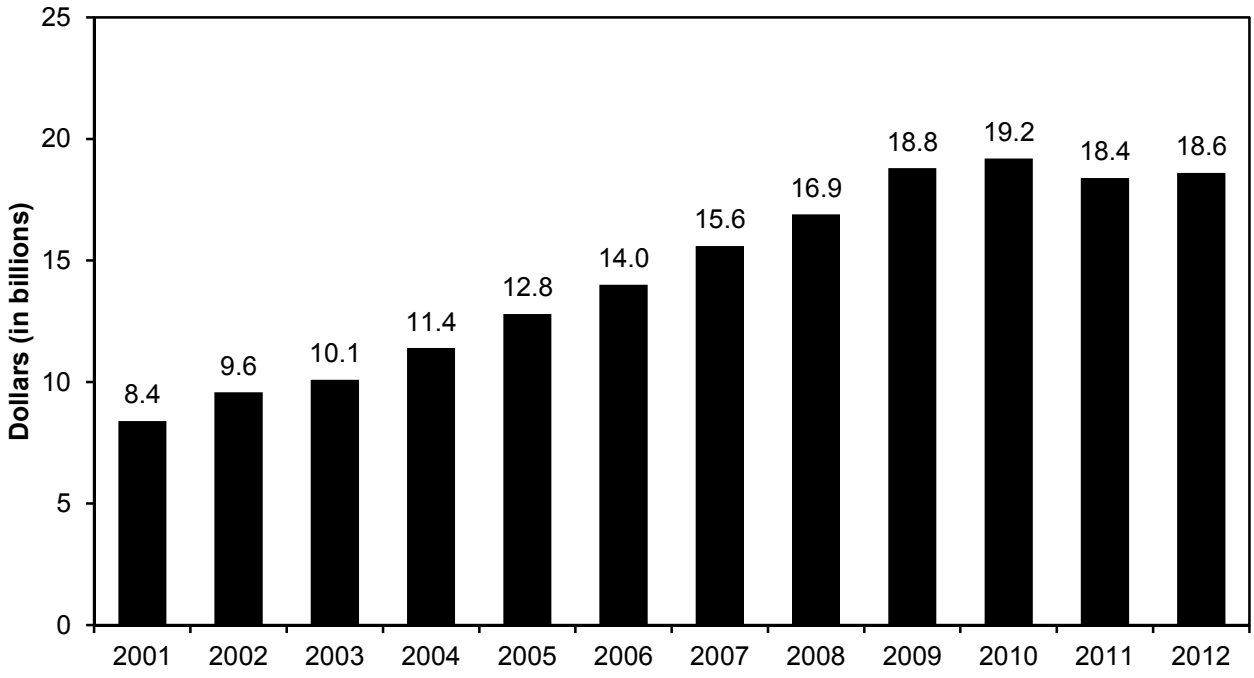
Characteristic	Percent of dual-eligible SNF users	Percent of other SNF users
Race/ethnicity		
White, non-Hispanic	72%	92%
African American	18	6
Hispanic	8	1
Other	3	1
Age (in years)		
<65	19	4
85+	28	39
Married	20	39
Falls since admission or prior assessment	23	16
Mental illness		
Alzheimer's disease	9	5
Dementia	33	21
Depression	46	33
Psychosis	9	3
Schizophrenia	5	1

Note: SNF (skilled nursing facility). Components may not sum to 100 percent due to rounding.

Source: Analysis of patient assessment data for fiscal year 2011. Kramer, A., R. Fish, and M. Min. 2013. Risk-adjusted quality measures for skilled nursing facilities in 2011. Report prepared for the Medicare Payment Advisory Commission.

- Dual-eligible users of SNFs are younger, more likely to be minority, and less likely to be married compared with other SNF users.
- Dual-eligible users of SNFs are more likely to have a mental illness or cognitive impairment compared with other SNF users.

Chart 8-8. Spending on home health care, 1997–2012



Source: MedPAC analysis of CMS Standard Analytic File, 2012.

- In October 2000, the prospective payment system (PPS) replaced the previous Medicare payment system. At the same time, eligibility for the benefit broadened slightly.
- Home health care has risen rapidly under PPS. Spending rose by about 10 percent a year between 2001 and 2009, but growth slowed beginning in 2010.
- Spending dropped by about $800 million in 2011. This decline was attributable to two factors: The base rate for home health care declined and Medicare implemented fraud safeguards to reduce excessive spending for these services. These changes curbed total spending in 2011, even though the number of episodes provided did not change significantly. Spending increased slightly in 2012.

Chart 8-9. Provision of home health care changed after the prospective payment system started

				Percent change	
	1997	2001	2011	1997–2001	2001–2011
Number of visits (in millions)	258	74	118	–71%	60%
Visit type (percent of total)					
Home health aide	48%	25%	15%		
Skilled nursing	41	50	51		
Therapy	10	24	33		
Medical social services	1	1	1		
Visits per home health patient	73	33	36	–55	9

Note: The prospective payment system began in October 2000. Totals may not sum to 100 percent due to rounding.

Source: Home health Standard Analytic File; Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2002.

- The types and amount of home health care services that beneficiaries receive have changed. In 1997, home health aide services were the most frequently provided visit type, and beneficiaries who used home health care received an average of 73 visits.

- By 2001, total visits dropped by 72 percent, and average visits per user had dropped to 33. The increase in visits per user between 2001 and 2011 reflects home health users receiving more episodes. The mix of services changed as well, with skilled nursing and therapy visits now accounting for over 80 percent of all services. Since the prospective payment system was implemented, the number of users and episodes has risen rapidly (see Chart 8-10).

Chart 8-10. Trends in provision of home health care

	2002	2006	2011	Average annual percent change 2002–2010
Number of users (in millions)	2.5	3.2	3.4	3.5%
Percent of beneficiaries who used home health care	7.2%	8.4%	9.5%	3.1
Episodes (in millions)	4.1	5.5	6.9	5.9
Episodes per home health patient	1.6	1.8	2.0	2.2
Visits per home health episode	18.4	18.4	17.2	-1.5
Visits per home health patient	31	34	34	1.2
Average payment per episode	$2,335	$2,538	$2,691	1.5

Source: MedPAC analysis of the home health Standard Analytic File.

- Under the prospective payment system, in effect since 2000, the number of users and the number of episodes have risen significantly. In 2011, 3.4 million beneficiaries used the home health benefit.
- The number of home health episodes increased rapidly from 2002 to 2011, though growth has slowed in recent years. The number of beneficiaries using home health care has also increased since 2002 but at a lower rate than the growth in episodes.
- The number of visits per episode decreased in 2002 to 2011. However, this decline was offset by an increase in the average number of episodes per patient, which increased from 1.6 in 2002 to 2.0 in 2011. Beneficiaries received fewer visits in an episode but had more 60-day episodes of care. As a result, the average number of episodes per home health user increased from 31 visits per home health user in 2002 to 34 visits per home health user in 2011.

Chart 8-11. Medicare margins for freestanding home health agencies

	2010	2011	Percent of agencies 2011
All	19.1%	14.8%	100%
Geography			
Mostly urban	19.1	14.8	86
Mostly rural	19.4	15.3	14
Type of control			
For profit	20.3	15.7	87
Nonprofit	15.1	12.2	13
Volume quintile			
First	10.2	6.6	20
Second	11.2	8.3	20
Third	13.5	10.1	20
Fourth	17.7	13.4	20
Fifth	22.0	17.4	20

Note: Agencies are characterized as urban or rural based on the residence of the majority of their patients. Agencies with outlier payments that exceeded 10 percent of Medicare revenues are excluded from the reported statistics.

Source: MedPAC analysis of 2010–2011 Cost Report files.

- In 2011, freestanding home health agencies (HHAs) (about 85 percent of all HHAs) had an aggregate margin of 14.8 percent. HHAs that served mostly urban patients in 2011 had an aggregate margin of 14.8 percent; those that served mostly rural patients had an aggregate margin of 15.3 percent. The 2011 margin is consistent with the historically high margins the home health industry has experienced under the prospective payment system. The margin from 2001 to 2010 averaged 17.7 percent, indicating that most agencies have been paid well in excess of their costs under prospective payment.

- For-profit agencies in 2011 had an average margin of 15.7 percent, and nonprofit agencies had an average margin of 12.2 percent.

- Agencies that serve more patients have higher margins. The agencies in the lowest volume quintile in 2011 have an aggregate margin of 6.6 percent, while those in the highest quintile have an aggregate margin of 17.4 percent.

Chart 8-12. Most common types of inpatient rehabilitation facility cases, 2012

Type of case	Share of cases
Stroke	19.5%
Fracture of the lower extremity	13.2
Neurological disorders	11.3
Major joint replacement	10.1
Debility	9.9
Brain injury	7.7
Other orthopedic	7.5
Cardiac conditions	5.1
Spinal cord injury	4.5
Other	10.9

Note: Other includes conditions such as amputations, major multiple trauma, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS (January through June of 2012).

- In 2012, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was stroke, representing close to 20 percent of cases.
- Major joint replacement cases represented 10 percent of IRF admissions in 2012, down from 24 percent in 2004, when major joint replacement was the most common IRF Medicare case type.
- The share of cases represented by patients with neurological disorders has been steadily increasing since 2004, while the share of major joint replacement cases has been steadily decreasing. In 2012, the share of neurological disorders exceeded the share of major joint replacement for the first time.

Chart 8-13. Volume of IRF FFS patients increased in 2011

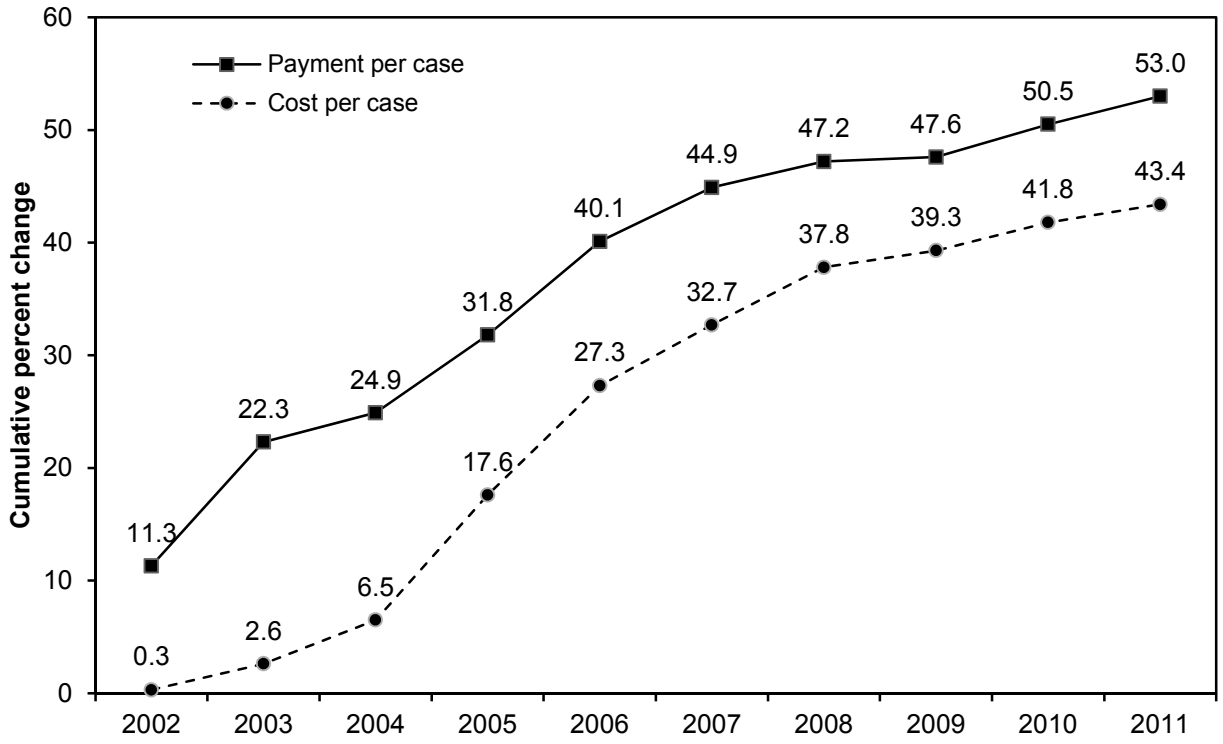
	2004	2009	2010	2011	Average annual percent change 2004–2010	Percent change 2010–2011
Number of IRF cases	495,000	364,000	359,000	371,288	–5.2%	3.3%
Unique patients per 10,000 FFS beneficiaries	123.0	93.0	91.1	92.7	–4.9	1.8
Payment per case	$13,290	$16,552	$17,085	$17,398	4.3	1.8
Medicare spending (in billions)	$6.58	$6.03	$6.14	$6.46	–1.1	5.2
Average length of stay (in days)	12.7	13.1	13.1	13.0	0.6	–0.8

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Numbers of cases reflect Medicare FFS utilization only.

Source: MedPAC analysis of MedPAR data from CMS.

- IRF volume is measured by the number of IRF cases and the number of unique patients per 10,000 beneficiaries, which controls for changes in FFS enrollment.
- IRF volume declined from 2004 through 2008, when enforcement of the compliance threshold was renewed. After 2008, the volume decline began to level off after the compliance threshold was permanently lowered to 60 percent.
- Between 2010 and 2011, the number of cases grew by 3.3 percent. This growth was due to an increase in both the number of unique beneficiaries receiving IRF care and an increase in the number of beneficiaries with more than one IRF stay in a year.
- While Medicare FFS spending on IRFs declined from 2004 through 2008, total Medicare spending rose 5.2 percent from 2010 to 2011.

Chart 8-14. Overall IRFs' payments per case have risen faster than costs since implementation of the PPS in 2002



Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system). Costs are not adjusted for changes in case mix.

Source: MedPAC analysis of cost report data from CMS.

- Since implementation of the PPS in 2002, overall Medicare payments per case have cumulatively increased faster than costs per case, although in most years from 2004 through 2009 costs per case grew faster than payments.
- Between 2010 and 2011, payments per case increased more than costs per case (2.5 percent payment growth compared with 1.6 percent cost growth).
- These trends in Medicare per case payments and costs are reflected in IRFs' Medicare margins, shown in Chart 8-15.

Chart 8-15. Inpatient rehabilitation facilities' Medicare margin by type, 2002–2011

	2002	2004	2006	2008	2009	2010	2011
All IRFs	10.8%	16.7%	12.4%	9.5%	8.4%	8.7%	9.6%
Hospital based	6.1	12.2	9.6	4.1	0.3	–0.3	–0.8
Freestanding	18.5	24.7	17.5	18.2	20.3	21.4	22.9
Urban	11.3	17.0	12.6	9.7	8.6	9.1	10.3
Rural	5.9	13.9	10.6	7.6	6.3	5.4	5.7
Nonprofit	6.5	12.8	10.7	5.6	2.3	2.0	2.0
For profit	18.5	24.4	16.3	16.7	19.0	19.8	21.3

Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of cost report data from CMS.

- Medicare margins increased rapidly during the first two years (2002–2004) of the IRF prospective payment system (PPS) across all provider types. Aggregate margins rose from just under 2 percent in 2001 to almost 17 percent in 2004.
- From 2004 through 2009, margins declined each year, largely due to reductions in patient volume through 2008 (resulting in fewer patients among whom to distribute fixed costs) and a zero update to the base rates for half of 2008 and for all of 2009 that resulted in Medicare payment rates remaining at 2007 levels. Margins rose in 2010 and 2011.
- Between 2010 and 2011, aggregate margins increased from 8.7 percent to 9.6 percent.
- Freestanding and for-profit IRFs had substantially higher aggregate Medicare margins than hospital-based and nonprofit IRFs, continuing a trend that began with implementation of the IRF PPS in 2002.

Chart 8-16. The top 25 MS–LTC–DRGs made up three-fifths of LTCH discharges in 2011

MS-LTC–DRG	Description	Discharges	Percentage	Change 2008–2011
207	Respiratory system diagnosis with ventilator support 96+ hours	16,101	11.5%	7.4%
189	Pulmonary edema and respiratory failure	13,042	9.3	49.1
871	Septicemia or severe sepsis without ventilator support 96+ hours with MCC	8,453	6.0	30.4
177	Respiratory infections & inflammations with MCC	4,997	3.6	15.1
592	Skin ulcers with MCC	3,425	2.5	–14.5
208	Respiratory system diagnosis with ventilator support <96 hours	3,029	2.2	21.8
949	Aftercare with CC/MCC	3,004	2.1	–19.9
190	Chronic obstructive pulmonary disease with MCC	2,769	2.0	8.2
193	Simple pneumonia and pleurisy with MCC	2,573	1.8	–4.6
539	Osteomyelitis with MCC	2,541	1.8	33.5
573	Skin graft and/or debridement for skin ulcer or cellulitis with MCC	2,101	1.5	9.9
314	Other circulatory system diagnosis with MCC	2,039	1.5	37.2
919	Complications of treatment with MCC	2,033	1.5	22.5
862	Postoperative and post-traumatic infections with MCC	2,008	1.4	20.1
166	Other respiratory system OR procedures with MCC	1,988	1.4	17.4
682	Renal failure with MCC	1,987	1.4	14.3
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR	1,887	1.4	33.5
559	Aftercare, musculoskeletal system, and connective tissue with MCC	1,808	1.3	–7.0
870	Septicemia or severe sepsis with ventilator support 96+ hours	1,774	1.3	64.6
291	Heart failure and shock with MCC	1,713	1.2	1.5
593	Skin ulcers with CC	1,615	1.2	–37.6
178	Respiratory infections and inflammations with CC	1,591	1.1	–19.0
603	Cellulitis without MCC	1,539	1.1	9.9
602	Cellulitis with MCC	1,451	1.0	27.5
560	Aftercare, musculoskeletal system, and connective tissue with CC	1,369	1.0	–17.3
	Top 25 MS–LTC–DRGs	86,837	62.0	12.8
	Total	139,741	100.0	6.8

Note: MS–LTC–DRG (Medicare severity–long-term care–diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), CC (complication or comorbidity), OR (operating room). MS–LTC–DRGs are the case-mix system for LTCHs. Columns may not sum due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Cases in LTCHs are concentrated in a relatively small number of MS–LTC–DRGs. In 2011, the top 25 MS–LTC–DRGs accounted for more than 60 percent of all cases.
- The most frequent diagnosis in LTCHs in 2011 was respiratory system diagnosis with ventilator support for more than 96 hours. Nine of the top 25 diagnoses, representing 34 percent of all cases, were respiratory conditions.

Chart 8-17. LTCH spending per FFS beneficiary continues to rise

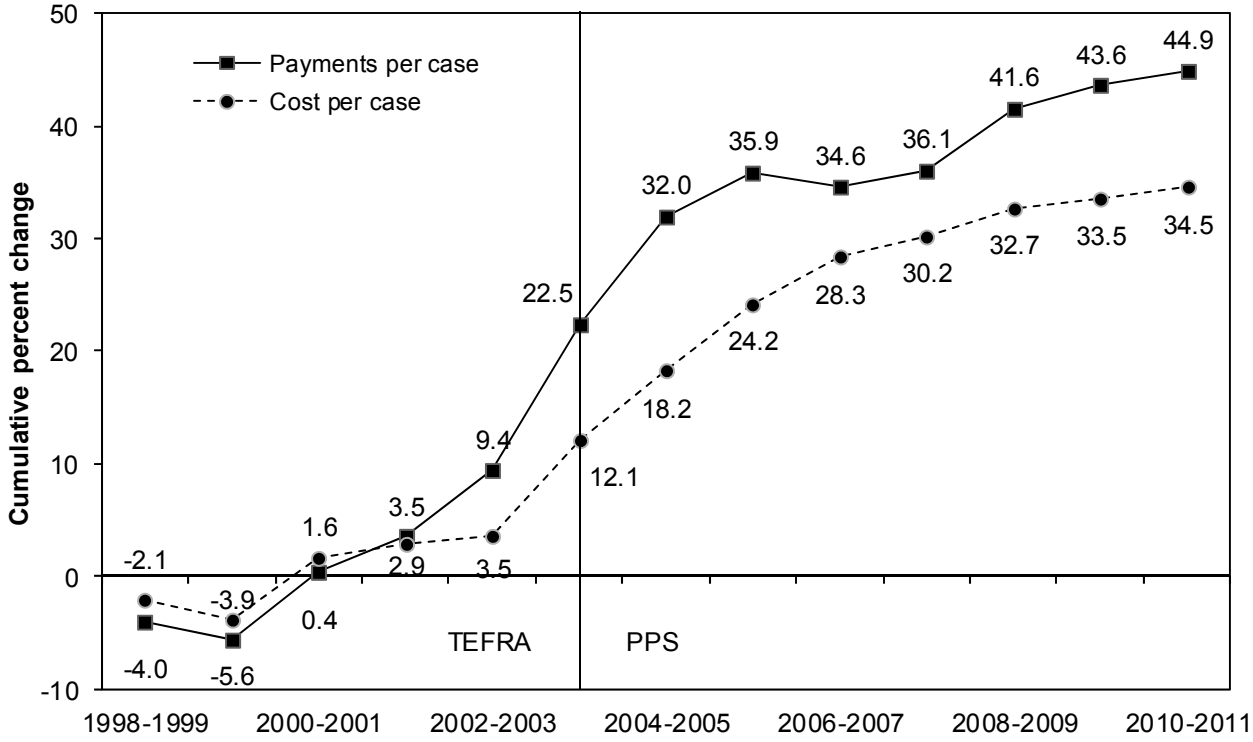
	2004	2005	2006	2007	2008	2009	2010	2011	Average annual change 2004–2005	2005–2010	2010–2011
Cases	121,955	134,003	130,164	129,202	130,869	131,446	134,683	139,715	9.9%	0.1%	3.7%
Cases per 10,000 FFS beneficiaries	33.4	36.4	36.0	36.2	36.9	37.0	37.4	38.5	9.0	0.6	2.8
Users	108,814	119,282	115,598	114,299	115,328	115,834	118,322	122,838	9.6	–0.2	3.8
Spending (in billions)	$3.7	$4.5	$4.5	$4.5	$4.6	$4.9	$5.2	$5.4	21.6	2.9	4.0
Spending per FFS beneficiary	$101.3	$122.2	$124.5	$126.1	$129.8	$138.0	$144.4	$148.8	20.7	3.4	3.1
Payment per case	$30,059	$33,658	$34,859	$34,769	$35,200	$37,465	$38,582	$38,664	12.0	2.8	0.2
Length of stay (in days)	28.5	28.2	27.9	26.9	26.7	26.4	26.6	26.3	–1.1	–1.2	–1.0

Note: LTCH (long-term care hospital), FFS (fee-for-service)

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Between 2010 and 2011, the number of beneficiaries who had LTCH stays (users) increased by 3.8 percent.
- Controlling for the number of FFS beneficiaries, the number of LTCH cases rose 2.8 percent between 2010 and 2011.
- The average length of stay in LTCHs continues to decline at a rate of about 1 percent per year. Since 2001, average length of stay has fallen 16 percent (not shown).

Chart 8-18. LTCHs' per case payments continue to increase more than costs



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Percent changes are calculated based on consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Payment per case increased rapidly after the PPS was implemented, climbing an average 16.6 percent per year between 2003 and 2005. Cost per case also increased rapidly during this period, albeit at a somewhat slower pace.

- Between 2005 and 2008, growth in cost per case outpaced that for payments, as regulatory changes to Medicare's payment policies for LTCHs slowed growth in payment per case to an average of 1.5 percent per year.

- Between 2008 and 2009, growth in payments per case accelerated to 5.5 percent, more than twice as much as the growth in costs. This surge was due in part to legislation that halted or rolled back the implementation of CMS regulations designed to address issues of overpayments to LTCHs.

- Between 2009 and 2011, growth in payments per case slowed to an average of 1.6 percent per year, while growth in costs per case increased less than 1 percent per year.

Chart 8-19. LTCHs' aggregate Medicare margin rose in 2011

Type of LTCH	Share of discharges	2004	2005	2006	2007	2008	2009	2010	2011
All	100%	9.1%	11.9%	9.7%	4.6%	3.5%	5.6%	6.6%	6.9%
Urban	95	9.3	12.0	9.9	4.9	3.8	5.9	6.9	7.1
Rural	4	2.6	10.2	4.7	–0.4	–3.3	–3.0	–0.3	1.1
Nonprofit	14	6.9	9.1	6.5	1.4	–2.5	–0.9	–0.2	–0.1
For profit	84	10.0	13.1	10.9	5.6	5.1	7.3	8.2	8.5
Government	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), N/A (not available). Share of discharges column groupings may not sum to 100 percent due to rounding or missing data. Margins for government-owned providers are not shown. They operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of cost report data from CMS.

- After implementation of the prospective payment system, LTCHs' Medicare margins increased rapidly for all LTCH provider types, climbing to 11.9 percent in 2005. Margins then fell as growth in payments per case leveled off. In 2009, however, LTCH margins began to increase again, reaching 6.9 percent in 2011.

- Margins increased between 2010 and 2011 for all types of LTCHs. Financial performance in 2011 varied across LTCHs. The aggregate Medicare margin for for-profit LTCHs (which accounted for 84 percent of all Medicare discharges from LTCHs) was 8.5 percent. Rural LTCHs' aggregate margin was 1.1 percent, compared with 7.1 percent for their urban counterparts. Rural providers account for about 4 percent of LTCH discharges, caring for a smaller volume of patients on average, which may result in poorer economies of scale.

Chart 8-20. LTCHs in the top quartile of Medicare margins in 2011 had much lower costs

Characteristics	Top-margin quartile	Bottom-margin quartile
Mean Medicare margin	20.6%	–9.2%
Mean total discharges (all payers)	553	428
Medicare patient share	61%	63%
Average length of stay (in days)	26	27
Mean adjusted CMI	1.0057	0.9454
Mean per discharge:		
Standardized costs	$27,160	$36,849
Medicare payment (excluding outlier payments)	$38,960	$35,027
High-cost outlier payment	$1,134	$4,434
Share of:		
Cases that are SSOs	27%	32%
Medicare cases from primary-referring ACH	39	44
LTCHs that are for profit	92	62

Note: LTCH (long-term care hospital), CMI (case-mix index), SSO (short-stay outlier), ACH (acute care hospital). Chart includes only established LTCHs—those that filed valid cost reports in both 2010 and 2011. Top-margin quartile LTCHs were in the top 25 percent of the distribution of Medicare margins. Bottom-margin quartile LTCHs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for differences in case mix and area wages. CMIs have been adjusted for differences in SSOs across facilities. The primary referring ACH is the one from which the LTCH receives a plurality of its patients. Government providers were excluded.

Source: MedPAC analysis of LTCH cost reports and MedPAR data from CMS.

- The top quartile of LTCHs had an aggregate Medicare margin of 20.6 percent, while the bottom quartile had an aggregate Medicare margin of –9.2 percent.
- Lower per discharge costs, rather than higher payments, drove the differences in financial performance between LTCHs with the lowest and highest Medicare margins. Bottom-margin LTCHs had standardized costs per discharge that were 36 percent higher than top-margin LTCHs ($36,849 vs. $27,160). Low-margin LTCHs served fewer patients overall and thus may have benefitted less from economies of scale.
- High-cost outlier payments per discharge for bottom-margin LTCHs were almost four times those of top-margin LTCHs ($4,434 vs. $1,134). At the same time, SSOs made up a larger share of bottom-margin LTCHs' cases. Bottom-margin LTCHs thus cared for disproportionate shares of patients who were high-cost outliers and patients who had shorter stays.
- Compared with their bottom-margin counterparts, top-margin LTCHs were much more likely to be for profit.

Web links. Post-acute care

Skilled nursing facilities

- Chapter 8 of MedPAC's March 2013 Report to the Congress provides information about the supply, quality, service use, and Medicare margins for skilled nursing facilities.

  http://www.medpac.gov/chapters/Mar13_Ch08.pdf

- Chapter 7 of MedPAC's June 2008 Report to the Congress provides information about alternative designs for Medicare's prospective payment system that would more accurately pay providers for their skilled nursing facility services.

  http://www.medpac.gov/chapters/Jun08_Ch07.pdf

- *Medicare payment basics: Skilled nursing facility payment system* provides a description of how Medicare pays for skilled nursing facility care.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_SNF.pdf

- The official Medicare website provides information on skilled nursing facilities, including the payment system and other related issues.

  http://www.cms.gov/medicare/medicare-fee-for-service-payment/SNFPPS/

Home health services

- Chapter 9 of MedPAC's March 2013 Report to the Congress provides information on home health services.

  http://www.medpac.gov/chapters/Mar13_Ch09.pdf

- *Medicare payment basics: Home health care services payment system* provides a description of how Medicare pays for home health care.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_HHA.pdf

- The official Medicare website provides information on the quality of home health care and additional information on new policies, statistics, and research as well as information on home health spending and use of services.

  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

Inpatient rehabilitation facilities

- Chapter 10 of MedPAC's March 2013 Report to the Congress provides information on inpatient rehabilitation facilities.

  http://www.medpac.gov/chapters/Mar13_Ch10.pdf

- *Medicare payment basics: Rehabilitation facilities (inpatient) payment system* provides a description of how Medicare pays for inpatient rehabilitation facility services.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_IRF.pdf

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

  http://www.cms.gov/medicare/medicare-fee-for-service-payment/InpatientRehabFacPPS/

Long-term care hospitals

- Chapter 11 of MedPAC's March 2013 Report to the Congress provides information on long-term care hospitals.

  http://www.medpac.gov/chapters/Mar13_Ch11.pdf

- *Medicare payment basics: Long-term care hospital services payment system* provides a description of how Medicare pays for long-term care hospital services.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_LTCH.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

  http://www.cms.gov//medicare/medicare-fee-for-service-payment/LongTermCareHospitalPPS/